Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005037	A. BUILDING _____ B. WING _____	C 01/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMERON MEMORIAL COMMUNITY HOSPITAL INC	416 E MAUMEE ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one State hospital complaint. Complaint Number: IN00119828 Unsubstantiated: Lack of Sufficient Evidence Date: 1/2/13 Facility Number: 005037 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Cameron Memorial Community Hospital, Inc. is in compliance with 410 IAC 15-1.6.2, Emergency Services, Hospital Licensure Rules. QA: claughlin 01/14/13	S 000		